



## Infant Health and Diet Questions

Birth through 1 year of age

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your baby's name: \_\_\_\_\_

Your baby's birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is your baby a Boy or a Girl: \_\_\_\_\_

**The following question is optional. Your answer will be used for reporting purposes. If you do not answer, the staff will make a selection for you. This does not affect you receiving WIC benefits.**

Is your baby Hispanic or Latino?       Yes     No

Is your baby Arabic?       Yes     No

Check **all** races that apply to your baby:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

What was your baby's birth weight: \_\_\_\_ pounds    \_\_\_\_ ounces

What was your baby's birth length: \_\_\_\_ inches

When was your baby born? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month    Day    Year

What was your due date? \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month    Day    Year

***Note to staff: Calculate Weeks Gestation with client's response and validate with EDD/ADD if available.***

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**Medical Information Screen**



1. **Medical conditions**/recent illnesses: WIC Staff will give you a list of medical conditions to review

2. Does your child take any **medicines**: (Check if yes)  If yes, what kind?

Any side effects?  Yes If yes, what?   No

3. Was this a:  single birth  triplet birth  
 twin birth  more than 3

4. Mother's Height:  ft  in 5. Mother's Weight:  lb

This should be answered by the **biological mother** only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

6. Father's Height:  ft  in 7. Father's Weight:  lb

This should be answered by the **biological father** only.

8. Does anyone living in your **household smoke** inside the home? (CDC)

Yes  No  Unknown

9. About how many hours did your child sit and **watch television** or videos yesterday? (CDC)

> 0 and < 1 hour  1 hour  2 hours  
 3 hours  4 hours  5 or more hours  
 None  Unknown

**BF Statistics Tab** (CDC)

Was this child ever breastfed or fed breast milk?

- Yes    No    Unknown

Is this child currently breastfed?

- Yes    No

How old was this child when he/she was **first fed** something other than breast milk?

- Exclusively Breastfed (**Check here if child has never had anything except breast milk**)

Age:      Months      Weeks      Days

	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Unknown
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Type of Food (Circle One)

Cereal Cow's Milk Formula Fruit Juice No Information Provided Vegetable Water
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**(Answer the next question if your child is no longer getting breast milk)**

How old was this child when he/she completely stopped breastfeeding or being fed breast milk?

Age:      Months      Weeks      Days

	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Unknown
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Reason Breastfeeding Ended (Circle One)

Baby distracted Breast/Nipple Pain Doctor recommended Infant/Child Illness/Condition Lack of Support Latch Issues/Refused Breast Low Milk Supply Maternal Illness/Surgery Medication Mother's Preference No Information Provided Other Return to School Return to Work Teething
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**Nutrition History Screen**



1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

Months     Weeks     Days

Type of Food Choices:     Cereal     Cow's Milk     Formula     Meat  
 Fruit     Juice     Vegetable     Water

2. Has your baby's health care provider/doctor said that your baby has or had:

- Jaundice
- A weak suck
- Poor weight gain
- Good weight gain
- Has inadequate bowel movements for age
- None apply

3. If breastfeeding who ends the nursing session?     Mom     Child

4. Does your infant sometimes take expressed breast milk from a bottle, cup or other?  
(Check if yes):

5. If expressing breast milk, do you feed fresh breast milk stored in the refrigerator for longer than 72 hours?  
 Yes     No

6. Is your infant drinking formula NOW? (Check if yes):

If yes, Formula Name:

7. If feeding formula, how much does your baby usually drink at a feeding?  Ounces

8. If feeding formula, is it stored:

At room temperature more than 2 hours?  Yes  No

In refrigerator more than 48 hours?  Yes  No

9. Do you have access to:

Safe water to prepare formula.  Yes  No

A refrigerator to store formula or breast milk.  Yes  No

10. Which appliances do you use to prepare formula?

Stove/range  Hot plate  Microwave  Other

11. Has your baby been given a bottle of formula or expressed breast milk left over from a previous feeding?

Yes  No

12. Is your infant? (Check all that apply):

Take a bottle to bed, nap or while lying down  Sip from a training cup throughout the day

Drink from a bottle propped up when feeding  Eat Finger foods

Eat from a spoon

Take a vitamin or mineral supplement daily  
What kind

Get cereal or infant food in a bottle/infant feeder  Use herbal supplement remedies or teas  
What kind

Receive sugar water

Have any dental problems

Receive juice in a bottle

Consume a vegetarian diet

Receive soda/pop in a bottle

Follow a special diet  
If yes, what type?

Use a bottle throughout the day as a pacifier

Take fluoride supplement

None apply

13. Does your baby eat or drink anything besides breast milk, formula and water?  Yes  No  
If yes, check what baby eats or drinks:

- |   |  |
|---|--|
| <input type="checkbox"/> Whole/low fat milk         | <input type="checkbox"/> Table Food    |
| <input type="checkbox"/> Imitation milk             | <input type="checkbox"/> Mixed Dinners |
| <input type="checkbox"/> Goat's/sheep's milk        | <input type="checkbox"/> Hot dogs      |
| <input type="checkbox"/> Vegetables                 | <input type="checkbox"/> Coffee/tea    |
| <input type="checkbox"/> Meats                      | <input type="checkbox"/> Candy/cookies |
| <input type="checkbox"/> Fruit                      | <input type="checkbox"/> Ice cream     |
| <input type="checkbox"/> Cereal                     | <input type="checkbox"/> Chips/donuts  |
| <input type="checkbox"/> Teething Biscuits          | <input type="checkbox"/> French Fries  |
| <input type="checkbox"/> Other <input type="text"/> |  |

14. Does your infant have any food allergies? (Check if yes)  If yes, to what?

15. Do you use sugar, honey or syrup on a pacifier?  Yes  No

16. Does your infant eat or drink any of the following? (Check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Raw (unpasteurized) juice or milk                                      | <input type="checkbox"/> Raw or undercooked (rare) meat, fish, poultry or egg                    |
| <input type="checkbox"/> Soft cheese(feta, camembert, Brie, queso blanco, queso fresco, Panela) | <input type="checkbox"/> Raw sprouts or raw or undercooked tofu                                  |
| <input type="checkbox"/> Honey  | <input type="checkbox"/> Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot |
| <input type="checkbox"/> None apply   |  |

17. Did the mother or this infant use alcohol or drugs during pregnancy?  Yes  No

18. Is the mother of this infant mentally impaired?  Yes  No

19. Has your infant been in foster care in the past 6 months?  Yes  No

20. Does a family member have a disability that would make it difficult to plan or prepare food for your baby?

Yes  No

**Staff Notes**

**CPA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_